

Mail

Herbal drugs ● Teaching in private practice

Ask patients which herbal drugs they smoke as well as eat

To the Editors,

Devoting an entire issue of the journal (September 1999) to alternative medicine is timely because alternative medicine has recently increased in popularity in the United States. The total 1997 out-of-pocket expenditures related to alternative therapies were conservatively estimated at \$27 billion; at the same time, a 380% increase was observed in the use of herbal remedies compared with 1990.1

Dong quai potentiates the anticoagulant effects of warfarin

Among the herbal drugs that may give rise to an adverse reaction, dang gui or dong quai (*Angelica sinensis*) was referred to in two of the articles.^{2,3} Unfortunately, no mention was made in either article of its interaction with warfarin sodium. Warfarin is one of the most commonly prescribed western medicines as an anticoagulant in the management of atrial fibrillation, which is the most common arrhythmia, found in 3.8% of the population older than 60 years and up to 11% in persons older than 70 years.⁴ Dong quai potentiates the anticoagulant effect of warfarin.

Another popular and commonly used herbal medicine that potentiates the anticoagulant effect of warfarin is danshen, which is a widely used Chinese herbal drug in cardiology for the treatment of various symptoms of coronary artery disease, including angina pectoris, myocardial infarction, and congestive heart failure.⁵⁻⁷ Danshen may be not only taken by mouth but also inhaled. It has become so popular that it has even been incorporated into some Chinese cigarettes.⁷ Therefore, in taking history from a Chinese patient, the physician should not only ask

which oral herbal drugs the patient is taking but also what brand of cigarettes he or she smokes.⁵

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Clinicians in private practice give generously in teaching time

To the Editors,

In his Letter from the Northwest Roberts reflects on the "overpowering greed for money in private practice." ¹ He states that the clinical decisions made and the ethics of private medicine are primarily driven by dollars. There is little hope, he says, of the academic and private sector sharing their special strengths. Although I agree with his concern over the divide between "town and gown," I do not share his opinion of the greed that he finds in private practice.

Colleagues and I recently completed a survey of clinical faculty who volunteer to teach at one institution (1996-1997) to determine

the total number of hours contributed by volunteer teaching and administration and to compare this with the number of full-time-equivalent staff. Forty-nine percent of 902 active clinical teachers responded to the survey. Altogether 168,230 hours were contributed by these volunteer teachers during the academic year studied; this corresponds to a total of 81 full-time-equivalent staff. This survey clearly shows that the volunteer clinical faculty were contributing a crucial number of teaching hours to medical students, house officers, and fellows. Those who were surveyed reported that the experience has been a positive one for both students and teachers. Many

volunteer faculty have been outstanding role models for their students as is shown by the students' evaluations of their teachers.

Today, both academic centers and those of us in private medicine face great challenges. In some areas, a greater proportion of teaching activity has shifted to the community and is being performed by volunteer clinical faculty. These programs have had little substantive support for this important educational effort. Because of the economic changes brought about by managed care, this important voluntary teaching activity is in danger of extinction. It is imperative that we develop and support the concept of depart-

ments of community-based medicine; these can be centers of excellence where community-based education is supported and nourished so that we will ensure the best possible outcome for the future.

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